Pharmacy Enrollment Form
HIV

Pharmacy Name	
Pharmacy Phone:	
Pharmacy Fax:	
Date Submitted:	
Submitted by:	

Ship to:	Date Needed:_____

PATIENT INFORMATION

Name:			
Preferred Name:			
Pronouns:		DOB:	
Address:			
City:	State:	Zip:	
Phone:	Alt Phone:		
Email:			
Sex:			
Gender Identity:	other		

PRESCRIBER INFORMATION

Name:		
Facility:		
Address:		
City:	State:	Zip:
Phone:	Fax:	
DEA:	NPI:	
Office Contact Name:		
Office Contact Phone:		
Office Contact Email:		

Insurance Information*

Plan Name:	
BIN:	
PCN:	
Group Number:	
ID Number:	
A copy of front and back of insurance card may be submitted with this form.	

Clinical Information

Allergies:	
Diagnosis/ICD 10:	B20 HIV
Diagnosis Date:	
Viral Load:	Date:
CD4 Count:	Date:
Serum Creatinine:	Date:

PRESCRIPTION INFORMATION

Prescriptions should be submitted to the pharmacy compliant to state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Faxed prescriptions may be accepted only if faxed directly by the prescriber or the prescriber's agent. Prescriptions will not be accepted if faxed by the patient.

Prior-Authorizations

To facilitate the prior-authorization process, please attach the following documents where appropriate and indicate which documents are attached.

☐ Failed therapies ☐ Recent office notes ☐ Recent lab work

Prescriber's Signature_____ Date_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I authorize Knu-Health pharmacy and/or its affiliate pharmacies to complete and submit prior authorization requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the prior authorization request as my signature.